Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE		ER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING			
NVN2536ADA						03/	29/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
STEP 2, IN	IC		3220 CORO RENO, NV	ONADO WAY 89503			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 000	Initial Comment			D 000			
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.  This Statement of Deficiencies was generated as a result of the State Licensure survey conducted at your facility on 3/29/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for 16 residential program beds for the treatment of abuse of alcohol and drugs. The census at the time of the survey was 16. Ten resident files and 10 employee files were reviewed. One discharged resident file was reviewed.						
D 100 SS=D	All persons employed in a facility must have documentation showing that they are in compliance with any applicable provisions of chapter 441A of NAC concerning tuberculosis.  This Regulation is not met as evidenced by: NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. (NRS 441A.120)  1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be		D 100				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED		
		NVN2536ADA			VING		29/2011
			STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
STEP 2, II			3220 CORO RENO, NV	ONADO WAY 89503			
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D 100	Continued From page	e 1		D 100			
	Centers for Disease adopted by reference subsection 1 of NAC 2. A medical facility, a home for individual maintain surveillance or home for tuberculcinfection. The surveil conducted in accordarecommendations of Control and Preventitransmission of tuber health care set forth Centers for Disease adopted by reference subsection 1 of NAC 3. Before initial emploin a medical facility, a home for individual a:  (a) Physical examinal licensed physician the good health, is free frany other communications and (b) Tuberculosis screepreceding 12 months history of bacillus Cavaccination.  If the employee has coff a 2-step Mantoux tube single-step tuberculo administered. A single screening test must be suppreceding test must be suppreceding test must be suppreceding test must be suppreceded to the suppreceded test and the suppreceded test	441A.200. a facility for the depend residential care shall of employees of the facility and tuberculosis lance of employees must ance with the the Centers for Disease on for preventing the reculosis in facilities proving the residential care shall had residential care shal	ent or cility st be e iding as oyed ent or ave n a step of the be ter,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
NVN2536ADA B. WING				03/29	03/29/2011		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
STEP 2, I	NC		3220 CORON RENO, NV 8				
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D 100	appropriate for a less documents that deter exposure and corresp examination must be guidelines of the Cen Prevention as adopte (h) of subsection 1 of 4. An employee with a positive tuberculosis from screening with s radiographs unless he suggestive of tubercu 5. A person who dem tuberculosis screening to subsection 3 shall and medical evaluatio 6. Counseling and prooffered to a person w screening test in according of the Centers for Dis Prevention as adopte (g) of subsection 1 of 7. A medical facility semployees for the desymptoms. A person or a positive tuberculo report promptly to the if any, or to the direction of the medical facility designated an infection any pulmonary symptom of tuberculosis are prevaluated for tuberculo fealth, eff. 1-24-92.  Based on record revien to the surround the surre that 1 of 1	er frequency of testing mination. The risk of conding frequency of determined by following ters for Disease Control d by reference in parage NAC 441A.200. In a documented history of screening test is exemply kin tests or chest is edevelops symptoms losis. In a constrates a positive great administered pursubmit to a chest radiogon for active tuberculosic eventive treatment mustiff a positive tuberculosic ease Control and d by reference in parage NAC 441A.200. In all maintain surveillance with a history of tuberculosic screening test shall infection control special or or other person in chaif the medical facility has on control specialist, whoms develop. If symptoms develop.	g the ol and graph of a ot suant graph is. It be sis ines graph ce of y ulosis II alist, harge as not nen oms hall be y Bd. 2006)	D 100			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME			(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN O	r CORRECTION	IDENTIFICATION NUMB	ER:	A. BUILDING	·	COMPL	ETED
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NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, STA	ATE, ZIP CODE		
STEP 2, INC			3220 CORO RENO, NV	NADO WAY 89503			
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PREFIX	,	CY MUST BE PRECEDED BY FU LISC IDENTIFYING INFORMAT		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE
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D 100	Continued From pag	je 3		D 100			
	examination).						
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	Severity: 2 Scope	e: 1					
D 216	NAC 449.141(8) Hea	alth Services		D 216			
SS=F							
		tial programs must unde					
		hat meets the requireme	ents				
	specified in chapter 4	441A of NAC.					
	This Regulation is n	ot met as evidenced by					
	_	ission of persons to cert					
		cilities for the dependent					
		residential care: Testing					
	respiratory isolation;						
	counseling and preven						
	documentation. (NRS						
	-	se provided in this section					
		erson to a medical facilit					
	extended care, skilled nursing or intermedi						
care, the staff of the facility shall ensure that chest radiograph of the person has been tak within 30 days preceding admission to the factorial ensurements. Except as otherwise provided in this section the staff of a facility for the dependent, a horizontal ensurements.							
		ne for					
	individual residential care or a medical facility for extended care, skilled nursing or intermediate		•				
			te				
	care shall:						
		a person to the facility o	PΓ				
	home, determine if the	ne person: · for more than 3 weeks;					
	(1) Has had a cough (2) Has a cough which						
	(3) Has blood in his s	•					
		h is not associated with	а				
	cold, flu or other app						
	(5) Is experiencing n						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  ANALYSIS A DA			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED - 03/29/2011		
		NVN2536ADA	OTDEET ADDE		TE 710 000E	03	Z3/ZU11
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR		I E, ZIP CODE		
STEP 2, II	NC		3220 COROI RENO, NV 8				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 216	(7) Has been in close has active tuberculos (b) Within 24 hours at person with a history (BCG) vaccination, is home, ensure that the screening test, unless qualified to administe home when the patient a person qualified to a facility or home when staff of the facility or hest is performed with person arrives at the days after the patient sooner. (c) If the person has a second to the second tuberculosis screening had an initial tubercul facility or home shall single tuberculosis screening had an initial tubercul facility or home shall single tuberculosis screening the tuberculosis screening had an initial tubercul facility or home shall single tuberculosis screening the tuberculosis screening that the riappropriate for a less documents that deter exposure and correspexamination must be guidelines as adopted (h) of subsection 1 of 3. A person with a dopositive tuberculosis sfrom skin testing and radiographs, but the services in the services of th	nexplained weight loss; contact with a person ris. Iter a person, including of bacillus Calmette-Guadmitted to the facility or person has a tubercul state is not a person riche test in the facility on the facility of the f	who a uerin or or losis or s not he the lified n 5 is step ithin that as has a and g the raph ot me	D 216			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  STEET ADDRESS, CITY, STATE, ZIP CODE  3220 CORONADO WAY RENO, NV 89503  STEET ADDRESS, CITY, STATE, ZIP CODE  3220 CORONADO WAY RENO, NV 89503  DEFICIENCY  SUMMARY STATEMENT OF DEFICIENCIES ((AA) ID PRECTIX (ADDRESS CITY, STATE, ZIP CODE  3220 CORONADO WAY RENO, NV 89503  DEFICIENCY)  D 216 Continued From page 5  annually for the presence or absence of symptoms of tuberculosis.  4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff Keeps the person in respiratory isolation, the staff shall not admit the person does not have active tuberculosis, the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person does not have active tuberculosis, the staff of the facility or home shall not admit the person to remain in the facility or home on the has already been admitted, shall not admit the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation in the facility or home, unless the facility or home keeps the person in respiratory isolation until a health care provider determines that the person does not have active tuberculosis, the staff of the facility or home, unless the facility or home keeps the person in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, alternative the person has respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, alternative the person has a subjected or in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, alternative the person has a subjected or a person that the person to more		or ricality care Quality c	1		1		1	
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STEP 2, INC   SUMMARY STATEMENT OF DEFICIENCIES   PROPRIETE   PR			NVN2536ADA	070557 40005		TE 710 0005	03/29	9/2011
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFEX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 216 Continued From page 5 annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person does not have active tuberculosis, the staff of the facility or home or, if he has already been admitted, shall not allow the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home, in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that,	NAME OF P	ROVIDER OR SUPPLIER				ATE, ZIP CODE		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  D 216  Continued From page 5  annually for the presence or absence of symptoms of tuberculosis.  4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person does not have active tuberculosis; the staff of the facility or home shall not admit the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis is the staff of the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that,	STEP 2, II	NC						
annually for the presence or absence of symptoms of tuberculosis.  4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person does not have active tuberculosis.  5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home on, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that,	PREFIX	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease	D 216	annually for the presessymptoms of tubercul 4. If the staff of the fathat a person has had weeks and that he has symptoms described subsection 2, the person facility or home if the respiratory isolation in guidelines of the Cen Prevention as adopte (h) of subsection 1 of health care provider of person has active tube able to keep the person the staff shall not addicare provider determined have active tubers. If a test or evaluation has suspected or active the facility or home of admitted, shall not all the facility or home, unkeeps the person in reperson must be kept health care provider of does not have active although the person in no longer infectious. In not certify that a person tinfectious unless obtained not less that sputum AFB smears separate days. 6. If a test indicates the or will be admitted to tuberculosis, the staff	ence or absence of losis. cility or home determined a cough for more thanks one or more of the other in paragraph (a) of son may be admitted to staff keeps the person a accordance with the ters for Disease Control of by reference in paragraph (A) of the staff is one in respiratory isolation in respiratory isolation in respiratory isolation in the person until a head the staff is one in respiratory isolation in the person until a head the staff is one in respiratory isolation in the person until a head the person until a head the person in dicates that a person in dicates that a person in the person to remain th	es a 3 her a the in all and graph not con, salth es con aff of a to a n in a e cuntil a son a that, he is shall cosis is r has gative a een active shall	D 216			

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPL		
		NVN2536ADA			B. WING		/29/2011
NAME OF PROVIDER OR SUPPLIER STREET ADDRES				RESS, CITY, STA	TE, ZIP CODE		72372011
			NADO WAY 89503				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 216	Continued From page	e 6		D 216			
	Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200.  The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.  8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person 's medical record.  (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006)  Based on record review on 3/29/11, the facility did not ensure that 9 of 10 residents met the requirements of NAC 441A.380 concerning tuberculosis - (Missing 2 step TB skin tests: Residents #2, #3, #7, #8 and #10); (Missing 2nd step TB skin tests: Residents #1, #4, #6, #9).  Severity: 2 Scope: 3						
D 250 SS=F	D 250 SS=F  NAC 449.147(6)(a-d) Dietary Services 6. A facility with more than 10 clients must: (a) Comply with all applicable provisions of			D 250			
	chapter 446 of NRS a pursuant thereto; (b) Obtain the necess of Health Protection S Division; (c) Maintain a report of	and the regulations ado sary permits from the B Services of the Health	ureau				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		BER:				DATE SURVEY COMPLETED	
				A. BUILDING			
		NVN2536ADA		B. WING		03/	/29/2011
NAME OF PROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
STEP 2, INC			3220 CORO RENO, NV	NADO WAY 89503			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 250	Continued From pag  1 year after the date (d) Maintain a report taken to address a d described in paragra the date of the corre  This Regulation is n Based on observatio review on 3-29-11, tl kitchen complied wit  Findings include:  1 Critical Violations:  a. Raw chicken was ready-to-eat romaine cauliflower in the GE refrigerator.	of the inspection; and of each corrective actio eficiency noted in a report ph (c) for at least 1 years ctive action.  ot met as evidenced by: In, interview and recording the facility failed to ensure the standards of NAC elettuce, broccoli, and it select reach-in kitchen the was provided during the select reach-in kitchen.	on ort r after re the 446.	D 250			
		itation Issues: es were not stored in 2-compartment kitchen	sink.				
		er the 2-compartment kit ed with kitchen debris, s ed materials.					
	Inc. contained unnec	ound both buildings of States dessary articles, pment, liter, and unorga					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING		(X3) DATE S COMPLE		
		NVN2536ADA		B. WING		03/	29/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
STEP 2, IN	ıc		3220 CORO RENO, NV	ONADO WAY 89503			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 250	Continued From page	e 8		D 250			
D 250	maintenance equipm were the back of the utility shed, base of the eastside of the main is 3. Equipment and Max a. The non-commerce refrigerator, located in properly closing at time b. Begin to replace a equipment used to st with commercial/NSF	ent. The areas observed property (south), around the driveway, and the shouse.  aintenance Issues:  cial GE select reach-ing the kitchen, was not the of inspection.  all household grade ore or prepare resident for grade equipment.  Irawer in the kitchen was perly closing.	d the	D 250			